

**VIRGINIA DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES
OFFICE OF PESTICIDE SERVICES
P. O. BOX 1163
RICHMOND, VIRGINIA 23218**

**WORKER PROTECTION STANDARD TRAINING VERIFICATION PROGRAM
STATE - TRAINING PROVIDER AGREEMENT**

I agree to issue EPA pesticide safety training verification cards to agricultural workers and/or handlers only in full compliance with the following requirements. I will:

1. Issue EPA training verification cards only to trainees who have been trained according to the requirement of the 1992 Federal Worker Protection Standard (40 CFR Part 170.130 and 170.230), including the correct use of training materials developed or approved by EPA.
2. Record trainee information on the verification cards, in ink or other indelible form.
3. Retain a copy of a dated class roster signed by the trainer and the trainee, with the card number issued to the trainee, and the city or county and state where the training occurred.
4. Issue EPA training verification cards that match EPA specifications or that comply with State variations from such specifications that have approval from EPA.
5. Promptly respond to requests from EPA, state, or agricultural employers for information concerning issued EPA training verification cards.

I certify that I am qualified to provide WPS training due to the following condition(s): (Please check applicable condition(s) and provide the appropriate information.)

+)),

Currently a certified applicator of restricted use pesticides.

.))-

Certificate # _____ Issuing State _____

+)),

Have completed a pesticide safety train-the-trainer program that has been approved by the Virginia Department of Agriculture and Consumer Services, Office of Pesticide Services.

.))-

Course Sponsor _____

Course Date _____ Course Number (VDACS Use Only) _____

I am aware that I may be subject to criminal penalties if I have made any statement of material facts knowing that such a statement is false or if I have willfully concealed any material fact. I am aware also that this voluntary agreement will make me subject to the provisions of FIFRA Section 12(a)(2)(M), "It shall be unlawful for any person to knowingly falsify all or part of any report filed under this Act"

PLEASE PRINT

Full Name: _____

Mailing Address: _____

NUMBER OF CARDS REQUESTED: _____ **WORKER** _____ **HANDLER** _____

Signature: _____ SSN: _____

Date: _____ Phone Number: _____